

(v) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

(3) *Frequency of index rate and plan-level adjustments.* (i) A health insurance issuer may not establish an index rate and make the market-wide adjustments pursuant to paragraph (d)(1) of this section, or make the plan-level adjustments pursuant to paragraph (d)(2) of this section, more or less frequently than annually, except as provided in paragraph (d)(3)(ii) of this section.

(ii) Beginning the quarter after HHS issues notification that the FF-SHOP can process quarterly rate updates, a health insurance issuer in the small group market (not including a merged market) may establish index rates and make the market-wide adjustments pursuant to paragraph (d)(1) of this section, and make the plan-level adjustments pursuant to paragraph (d)(2) of this section, no more frequently than quarterly, provided that any changes to rates must have effective dates of January 1, April 1, July 1, or October 1.

(e) *Grandfathered health plans in the individual and small group market.* A state law requiring grandfathered health plans described in §147.140 of this subchapter to be included in a single risk pool described in paragraphs (a) through (c) of this section does not apply.

(f) *Applicability date.* The provisions of this section apply for plan years (as that term is defined in §144.103 of this subchapter) in the group market, and for policy years (as that term is defined in §144.103 of this subchapter) in the individual market, beginning on or after January 1, 2014.

[78 FR 13441, Feb. 27, 2013, as amended at 78 FR 39898, July 2, 2013; 78 FR 65096, Oct. 30, 2013]

Subpart B—Essential Health Benefits Package

SOURCE: 78 FR 12866, Feb. 25, 2013, unless otherwise noted.

§ 156.100 State selection of benchmark.

Each State may identify a single EHB-benchmark plan according to the selection criteria described below:

(a) *State selection of base-benchmark plan.* The options from which a base-benchmark plan may be selected by the State are the following:

(1) *Small group market health plan.* The largest health plan by enrollment in any of the three largest small group insurance products by enrollment, as defined in §159.110 of this subpart, in the State's small group market as defined in §155.20 of this subchapter.

(2) *State employee health benefit plan.* Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.

(3) *FEHBP plan.* Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 USC 8903.

(4) *HMO.* The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.

(b) *EHB-benchmark selection standards.* In order to become an EHB-benchmark plan as defined in §156.20 of this subchapter, a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in §156.110 of this subpart; and

(c) *Default base-benchmark plan.* If a State does not make a selection using the process defined in §156.100 of this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State's small group market. If Guam, the U.S. Virgin Islands, American Samoa, or the Northern Mariana Islands do not make a benchmark selection, the default base-benchmark plan will be the largest FEHBP plan by enrollment.

§ 156.105 Determination of EHB for multi-state plans.

A multi-state plan must meet benchmark standards set by the U.S. Office of Personnel Management.

§ 156.110 EHB-benchmark plan standards.

An EHB-benchmark plan must meet the following standards: